

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06845

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06838

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Victoria		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Victoria	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Victoria		d. STREET ADDRESS 09-1	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH Month 5 Day 16 Year 1966	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (In years last birthday) yrs. 66 IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66
11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Don Brown		14. MOTHER'S MAIDEN NAME Grace Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-16-8961	
17. INFORMANT Wife- Nannie C. Brown, Newburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 5/17/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-19-66	23c. NAME OF CEMETERY OR CREMATORY Shilo M.E. Cemetery	23d. LOCATION (City or Town) (County) (State) Shilo, Charles Co., Md.
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR MAY 23 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

36

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Charles MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marshall Hall			c. LENGTH OF STAY IN 1b 29 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marshall Hall			d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles Daniel Busey First Middle Last					4. DATE OF DEATH 5-6-1966		Month Day Year 5-6-1966 19		
5. SEX Male		6. COLOR OR RACE W-US		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-31-1903		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer (Retired)			10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Busey					14. MOTHER'S MAIDEN NAME Eva Young				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 578-09-8744		17. INFORMANT Wife-Theresa Busey -Marshall Hall Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Upper Respiratory Infection-Viral DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Immediate 2-Mths.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-1-1966, 19, to 5-6-1966 19, that (I) (we) last saw the deceased alive on 5-6-66 19, and that death occurred at 3-30 PM from the causes and on the date stated above.									
22a. SIGNATURE James E. Andrews MD					22b. DATE SIGNED 5-6-66			22c. PHYSICIAN'S NAME (Type) James E. Andrews MD	
22d. ADDRESS Indian Head Md									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 5/10/1966		23c. NAME OF CEMETERY OR CREMATORY St. Barnabase Cemetery			23d. LOCATION (City, town or county) (State) Lrland, Prince Geo., Md.		
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.					25a. REC'D BY REGISTRAR MAY 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Issue (Rural) c. LENGTH OF STAY IN lb Issue (Rural) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue (Rural) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOWNDES BUTLER						4. DATE OF DEATH Month May Day 26 Year 1966					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 26, 1893		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 02 Days 01	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James H. Butler						14. MOTHER'S MAIDEN NAME Julia (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-09-4237		17. INFORMANT Annie Lewis Address Annie Lewis-Niece-Newburg, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026x Cerebral Spinal Syphilis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-23-66 to 5-26-66 , that (I) (we) last saw the deceased alive on 5-23-66 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.											
22a. SIGNATURE F. M. JOHNSON MD						22b. DATE SIGNED 5-27-66			22c. PHYSICIAN'S NAME (Type) F. M. JOHNSON MD		
22d. ADDRESS LA PLATA, Md						22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/28/1966		23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery			23d. LOCATION (City, town or county) (State) Issue, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc.						25a. REC'D BY REGISTRAR JUN 3 1966			25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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THE NATIONAL BUREAU OF INVESTIGATION

100-100000

REPORT OF AGENT

DATE: MAY 1, 1936

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

[Large block of illegible handwritten text, likely a memorandum or report body]

APPROVED: [Illegible Signature] DATE: MAY 1, 1936

RECEIVED: [Illegible] MAY 1, 1936

FOR STATE HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Marshall Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1783 Congress St SE.	
3. NAME OF DECEASED (Type or print) First Middle Last Randall L. CRISLIP		4. DATE OF DEATH Month Day Year 5 14 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1940
9. AGE (In years lost birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) New Milton W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chas Crislip		14. MOTHER'S MAIDEN NAME Opal Swisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 236-62-1141	
17. INFORMANT Virginia M Crislip		Address 1783 Congress St SE Washington D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Carbon monoxide poisoning (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inhaled CO exhaust gas from car	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 5 14 19 66 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, street, office bldg., etc.) street		20f. (City or town) (County) (State) Highway near Marshall Hall	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breiteneker EXAMINER'S NAME (Type)		22. DATE SIGNED 5/15/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 5-17-66	
23c. NAME OF CEMETERY OR CREMATORY Childers		23d. LOCATION (City or Town) (County) (State) New Milton W. Va.	
24. FUNERAL DIRECTOR Chapman Funeral Home Inc		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 1014 S. Capitol St		25b. REGISTRAR'S SIGNATURE Charles Judge	

MAY 18 1966

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 3-76 5/6/66 mn

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06850

06843

1. PLACE OF DEATH a COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Charles	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury Md		c LENGTH OF STAY IN 1b 22-Years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Earl M. Crismond		4. DATE OF DEATH 5-1-66	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-5-1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Building	9. AGE (In years last birthday) 55 1/2
13. FATHER'S NAME Otis Crismond		14. MOTHER'S MAIDEN NAME Lizzie Rawlet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-09-2279	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Generalised Arterio Sclerosis DUE TO (c) Indefinite		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 5-1-66	
ACTUAL SIGNATURE James E. Andrews MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James E. Andrews MD		23b. DATE THEREOF 5-2-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORY Park Hill	
24. FUNERAL DIRECTOR Archart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR MAY 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		23d. LOCATION (City or Town) (County) (State) Marbury, Charles Co., Md.	

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VR AIS (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Indian Head</u> c. LENGTH OF STAY IN b. <u>Indian Head</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Indian Head</u> d. STREET ADDRESS <u>#38 Mattingly Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Eugene Gardiner</u> First Middle Last 4. DATE OF DEATH <u>May 25 1966</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cau.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 17 1882</u> last birth day yrs. Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman (ret.)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Plant</u> 11. PLACE OF BIRTH (County & State, or foreign country) <u>Charles Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Marcellus Gardiner</u> 14. MOTHER'S MAIDEN NAME <u>Maggie Sanders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>220-44-2335</u> 17. INFORMANT <u>Mrs. Marie McWilliams</u> Address <u>Indian Head Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA STOMACH</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> , 19 <u>66</u> to <u>5/25</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5/24</u> , 19 <u>66</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Frank A. Susan</u> M.D. 22b. ADDRESS <u>Indian Head, Md.</u> 22c. PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u> 22d. ADDRESS <u>Indian Head, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5-28-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u> 23d. LOCATION (City, town or county) <u>Waldorf, Md.</u> (State) _____		25a. REC'D BY REGISTRAR <u>MAY 31 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06852

06845

1 PLACE OF DEATH a. COUNTY Charles MARYLAND		2 USUAL RESIDENCE (Where deceased lived f inst funtion Residence before admiss on) a. STATE South Carolina b. COUNTY Hartsville	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 77-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LaPlata Hospital		d. STREET ADDRESS 77-3	
3. NAME OF DECEASED (Type or print) First Middle Last Gus Haney		4. DATE OF DEATH Month Day Year 5/ May 16 19 66	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 9, 1924
9 AGE (In years lost birthday) yrs 41		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
10b. KIND OF BUSINESS OR INDUSTRY Darlington Co., S.C.		11 BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Richard Haney		14. MOTHER'S MAIDEN NAME Lula Reynolds	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or Unknown) (If yes give war or dates of serv co) NO		16 SOCIAL SECURITY NO Unkown	
17 INFORMANT Mrs. Sarah Ann McInnis -Hartsville,		Address S.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardiovascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 5/17/66	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 5/20/1966	23c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery	23d. LOCATION (City or Town) (County) (State) Hartsville, South Carolina
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.		25a. REC'D BY REGISTRAR MAY 23 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
06853										
CERTIFICATE OF DEATH										
Reg. Dist. No. 06846										
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>					c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <u>Katie Marie Hill</u>					4. DATE OF DEATH <u>May 17 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs		
						IF UNDER 1 YEAR		IF UNDER 24 HRS.		
						Months		Days		
						Hours		Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>					
11. BIRTHPLACE (State or foreign country) <u>St. Marys Co. Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Daniel Buckler</u>					14. MOTHER'S MAIDEN NAME <u>Bertie Buckler</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u>					16. SOCIAL SECURITY NO <u>578-28-8966</u>					
					17. INFORMANT <u>C. Frank Hill, Hughesville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>1966</u> , that I last saw the deceased alive on <u>11/28 1966</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Leon Berube</u>					ADDRESS (Street, city or town, state) <u>Mechanicsville, Md.</u> DATE SIGNED <u>May 17, 1966</u>					
PHYSICIAN'S NAME (Type) <u>Leon Berube</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>			<u>May 21, 1966</u>		<u>St. Marys</u>			<u>Bryantown, Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Shalidor, Md.</u>					24a. REC'D BY REGISTRAR <u>MAY 23 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

06854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06847

1 PLACE OF DEATH a. COUNTY Charles		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf Md		c. LENGTH OF STAY IN 1b Passing Through	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. STREET ADDRESS Pisgah Md	
3 NAME OF DECEASED (Type or print) James L/ L. Luttrell		4 DATE OF DEATH Month 5 Day 29 Year 1966	
5 SEX Male	6 COLOR OR RACE W-US	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-2-1917
9 AGE (In years last birthday) 49 yrs		10 IF UNDER 1 YEAR Months 1 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer		10b. KIND OF BUSINESS OR INDUSTRY US. Govt. GSA.	
11 BIRTHPLACE (State or foreign country) Winchester Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roy H. Luttrell		14. MOTHER'S MAIDEN NAME Carey H. Dix	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 577-05-3849	
17 INFORMANT Mary Milstead - Daughter		Address Indian Head	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Coronary Occlusion, Massive DUE TO (b) Arterio Sclerosis DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) James E. Andrews MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 5-29-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-1-66	
23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		23d. LOCATION (City or Town) (County) (State) WALDORF, MD.	
24. FUNERAL DIRECTOR The HUNTT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR JUN 1 1966	
25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

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TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
66855					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					06848			
1 PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA c. LENGTH OF STAY IN 1b LA PLATA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIANS MEMORIAL HOSPITAL					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata d. STREET ADDRESS 18-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3 NAME OF DECEASED (Type or print) HERBERT W. LYLES			4. DATE OF DEATH Month 5 Day 7 Year 1966			5 SEX Male				6 COLOR OR RACE Colored			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8 DATE OF BIRTH 3/22/1966			9 AGE (In years last birthday) 16 wks		F UNDER 1 YEAR Months 16 Days 4		F UNDER 24 HRS Hours 4 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT			10b. KIND OF BUSINESS OR INDUSTRY LA PLATA, M.D.			11. BIRTHPLACE (State or foreign country) U.S.A.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13 FATHER'S NAME WILLIAM FRANCIS PROCTOR			14 MOTHER'S MAIDEN NAME MARY ANN LYLES										
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16 SOCIAL SECURITY NO NONE			17 INFORMANT MARY ANN LYLES - MOTHER - LA PLATA Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 7571 DUE TO Congenital polycystic renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour am 19 p.m.			20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)			20f. (City or town) (County) (State)				
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 5-9-66	
EXAMINER'S NAME (Type)			Address (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 5/10/66			23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY			23d. LOCATION (City or Town) (County) (State) LA PLATA, MD				
24. FUNERAL DIRECTOR Archard Funeral Home, Inc. La Plata, Md.			25. REG'D BY REGISTRAR MAY 16 1966			25b. REGISTRAR'S SIGNATURE Charles Judge							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Ches.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pomoxe</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pomoxe</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <i>JOSEPH HAROLD MARSHALL</i>					4. DATE OF DEATH Month <i>5</i> Day <i>15</i> Year <i>1966</i>				
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>AUG. 22ND 1938</i>		9. AGE (In years last birthday) <i>27</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>JAMES K. MARSHALL</i>					14. MOTHER'S MAIDEN NAME <i>MARY TAAVIS</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes U.S. ARMY</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>VILIAN D. MARSHALL</i> Address <i>Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Compound Comminuted Fracture of Humerus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to</i> (c) <i>Due to</i>								INTERVAL BETWEEN ONSET AND DEATH <i>5-15-66</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? - YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of car while now under moving loads</i>					
20c. TIME OF INJURY Month, Day, Year <i>3:00 a.m. 5-15-66</i>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Heavy Duty Metal Shop</i>		20f. (City or town) <i>MD</i> (County) <i>Ches.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. J. E. DELEN</i>					22. DATE SIGNED <i>5-15-66</i>				
EXAMINER'S NAME (Type) <i>E. J. E. DELEN</i>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE THEREOF <i>5/20/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT.</i>		23d. LOCATION (City, town or county) (State) <i>ARLINGTON VA.</i>		
24. FUNERAL DIRECTOR <i>JOHNSON FUNERAL HOME</i> ADDRESS <i>Pomoxe MD</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
					DATE <i>MAY 24 1966</i>				

TO HOSPITAL OF [REDACTED] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any agent, within 72 hours after death.

VR A15 (4)
ISM 9/60

death. Page 4 ma
TO FUNERAL. DI

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06857

06850

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 yrs</u>		d. STREET ADDRESS <u>67-1</u>	
3. NAME OF DECEASED (Type or print) <u>Emily DeLozier Mattingly</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 8, 1889</u>	
9. AGE (In years, last birthday) <u>76</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Mins.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
12. FATHER'S NAME <u>Henry DeLozier</u>		13. MOTHER'S M maiden NAME <u>Caroline Robie</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. SOCIAL SECURITY NO. <u>216-38-6134</u>	
16. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Fracture Right Hip</u>		17. ADDRESS <u>J. A. Murdock, Morbury, Md.</u>	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1964</u> to <u>May 12, 1966</u> that (I) (we) last saw the deceased alive on <u>May 12, 1966</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above		22a. SIGNATURE <u>Frank A. Susan</u> M.D.	
22b. PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		22c. ADDRESS <u>Rt. 1 Box 50, Indian Head, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-15-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PISGAH NAZARENE</u>		23d. LOCATION (City, town or county) (State) <u>PISGAH, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT FUNERAL HOME, WALDORF, MD.</u>		25. REC'D BY REGISTRAR <u>MAY 17 1966</u>	
26. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

06858

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 File G377 / 25/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06851

1 PLACE OF DEATH a COUNTY <u>Charles</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Charles</u>					
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Laurel Waldorf</u>			c LENGTH OF STAY IN 1b			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 424</u>				d STREET ADDRESS <u>Box 424</u>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>ARLENE</u> Last <u>PEERY</u>				4 DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1966</u>					
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Jan. 8, 1923</u>		9 AGE (In years, months, and days) <u>43</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11 BIRTHPLACE (State or foreign country) <u>Smithers, W. Va.</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13 FATHER'S NAME <u>Bernard Smith</u>				14 MOTHER'S MAIDEN NAME <u>Beulah Scaggs</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>234-20-5973</u>		17 INFORMANT <u>Mr. Donald Perry - Husband - Waldorf, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>330x</u> DUE TO (b) <u>Rupture of aneurysm of Circle of Willis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____								INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)				22. DATE SIGNED <u>May 7 66</u>	
23a BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b DATE THEREOF <u>5/9/1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cunningham Mem. Park</u>		23d LOCATION (City or town) (County) (State) <u>St. Alban's, West Virginia</u>			
24 FUNERAL DIRECTOR <u>Snodgrass Funeral Home</u>				ADDRESS <u>West Virginia</u> <u>South Charleston</u>				25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MAY 11 1966

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06852

1 PLACE OF DEATH a COUNTY CHARLES b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c LENGTH OF STAY IN 1b La Plata		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE MARYLAND b COUNTY CHARLES c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - RURAL	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physician's Memorial		d STREET ADDRESS 219 S. ROBINSON ST. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last ANNA OL PRILLER		4 DATE OF DEATH Month Day Year May 17 1966	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 29, 1922 9 AGE (In years last birthday) yrs 43
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (State or foreign country) Baltimore, Maryland 12 CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Charles Osusky		14. MOTHER'S MAIDEN NAME Anna Cechotovskiy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-12-6496	
17 INFORMANT Frederick Priller		Address 219 S. Robinson Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive intrapulmonary hemorrhage and edema 5024 DUE TO (etiology undetermined) (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____ _____ _____
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. ____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____ _____ _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Brietenecker EXAMINER'S NAME (Type) Rudiger Brietenecker, M.D.		22. DATE SIGNED 5-18-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-21-1966	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Lilly & Zeiler Inc.		25a. REC'D BY REGISTRAR DATE MAY 19 1966 25b. REGISTRAR'S SIGNATURE J. Charles Jones	
ADDRESS 1901 Eastern Avenue			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME (5)
6M 1/66

06850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06850

1 PLACE OF DEATH COUNTY Charles STATE Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland COUNTY Charles	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c LENGTH OF STAY IN b Cobb Island	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial LaPlata Md		d STREET ADDRESS 0 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Arthur Sargent		4 DATE OF DEATH Month 5 Day 30 Year 66	
5 SEX Male	6 COLOR OR RACE W-US	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-1-1983
9 AGE (In years last birthday) 82		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Machinist		10b KIND OF BUSINESS OR INDUSTRY Printing	
11 BIRTHPLACE (State or foreign country) Washington D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME George W. Sargent		14 MOTHER'S MAIDEN NAME Annie Wilkerson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO 220-44-7500	
17 INFORMANT Arnold F. Sargent, Mechanicsville Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO (b) Arterio-Sclerosis General DUE TO (c) Aging Process			INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James E. Andrews		22. DATE SIGNED 5-30-66	
EXAMINER'S NAME (Type) James E. Andrews		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6/3/66	23c NAME OF CEMETERY OR CREMATORY Rock Creek Cem.	23d LOCATION (City or town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Lee Funeral Home 3004th St. N.E. Wash. D.C.		25a. REC'D BY REGISTRAR Charles Judge	

JUN 6 1966

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06854

1. PLACE OF DEATH Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. LENGTH OF STAY IN 1b 30-Minutes Faulkner	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial LaPlata Md		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL E. SWANN		4. DATE OF DEATH Month 5 Day 31 Year 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 30-Min.
11. BIRTHPLACE (State or foreign country) Faulkner Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Swann		14. MOTHER'S MAIDEN NAME Margaret Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Margaret Swann - Mother		Address Faulkner Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X Prematurity-Five Month Gestatio. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mother was alone child was born and mother said that it lived about thirty minutes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James E. Andrews MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 5-31-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/4/1966		23b. DATE THEREOF 6/4/1966	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Newport, Md	
24. FUNERAL DIRECTOR Archard Funeral Home		25. REC'D BY REGISTRAR DATE JUN 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

08034

08034

08034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06862 CERTIFICATE OF DEATH 06853

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>		d. STREET ADDRESS <u>09-1</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES REEDER WILLIAMS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20 1890</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ross Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Bowman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>6-27-1852-1749</u>	
17. INFORMANT <u>Mrs. Mary A. Murphy</u>		Address <u>Hughesville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant metastases (bone & abdomen)</u> 177X DUE TO (b) <u>Ca - prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Fadley</u>		22b. DATE SIGNED <u>5-5-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Fadley M.D.</u>		22d. ADDRESS <u>Garwood Clinic, La Plata Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-6-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City, town or county) (State) <u>Bryantown, Md.</u>	
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, St. Michaels, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 9 1966</u>	

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OF THE
ATTORNEY
GENERAL
STATE OF
NEW YORK
ALBANY
JANUARY 15 1900